Administrative Rules Concerning Medical Fee Dispute Resolution

(IDAPA 17.02.08.31 and 17.02.08.32)
(Dates in parentheses indicate date of adoption.)

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES UNDER THE IDAHO WORKERS' COMPENSATION LAW.

Pursuant to Idaho Code, Section 72-508 and Section 72-803, the Industrial Commission (hereinafter "the Commission") hereby substitutes the following for the January 28, 1975 amendment to the "Rules and Regulations Governing Charges for Medical Services Provided under the Idaho Workers' Compensation Law," dated May 2, 1973: (6-1-92)

01. Acceptable Charges Under the Idaho Workers' Compensation Law. Payors shall pay a Provider's reasonable charge for Medical Services furnished to industrially injured patients. (6-1-92)

02. Definitions. Words and terms used in this rule are defined in the subsections which follow. (6-1-92)

a. "Provider" means any person, firm, corporation, partnership, association, agency, institution or other legal entity providing any kind of Medical Services related to the treatment of an industrially injured patient which are compensable under Idaho's Workers' Compensation Law. (6-1-92)

b. "Payor" means the legal entity responsible for paying medical benefits under Idaho's Workers' Compensation Law. (6-1-92)

c. "Medical Services" means medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicines, apparatus, appliances, prostheses, and related services, facilities, equipment and supplies. (7-1-95)

d. "Reasonable," except as provided in Subsections 031.02.g. and 031.02.h., means a charge does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined below. (7-1-95)

e. "Usual" means the most frequent charge made by an individual Provider for a given service to non-industrially injured patients. (7-1-95)

f. "Customary" means a charge which shall have an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given service. (7-1-95)

g. Provided, however, that for medical services which are not represented by CPT codes, reasonableness of charges shall be determined based on all relevant evidence available, including industry standards, invoices and catalog prices. (7-1-95)

h. Provided, further, that where a Medical Service is one that is exceptional, unusual, variable, rarely provided, or so new that a determination cannot be made as to whether the charge for the Medical Service meets the criteria of Subsections 031.02.d. through 031.02.f. above, or where the Industrial Commission staff determines that its database is statistically unreliable, reasonableness of charges shall be determined based on all relevant evidence available. (7-1-95)

032. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES
PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority and Definitions. Pursuant to Idaho Code Section 72-508 and Section 72-803, the Industrial Commission hereby promulgates this rule augmenting IDAPA 17.02.08.031 (formerly 17.01.03.803.A, which became effective June 1, 1992). The definitions set forth in IDAPA 17.02.08.031 are incorporated by reference as if fully set forth herein. (1-1-93)

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (1-1-93)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of Medical Services furnished and for which the bill is submitted. This information shall include, but is not limited to, the patient's name, the employer's name, the date the Medical Service was provided, the diagnosis, if any, and the amount of the charge or charges. (1-1-93)

a. CPT and ICD Coding. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, for the year in which the service was performed and using current International Classification of Diseases (ICD) diagnostic coding, as well. (7-1-95)

b. Contact Person. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (1-1-93)

c. Report to Accompany Bill. If required by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04.322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 032.04 and 032.06, below, shall not begin to run until the Payor receives the Report. (7-1-95)

04. Prompt Payment. If the Payor acknowledges liability for the claim and does not send a Preliminary Objection to, or Request for Clarification of, any charge, as provided in Subsection 032.06, below, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other

provisions of this rule will generally be sufficient to protect a party's rights hereunder. (1-1-93)

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 032.06 below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection and/or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other provisions of this rule will generally be sufficient to protect a party's rights hereunder. (7-1-95)

06. Preliminary Objections and Requests for Clarification. (1-1-93)

a. Preliminary Objection. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (1-1-93)

b. Request for Clarification. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (1-1-93)

c. Provider Contact. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual the Provider may contact regarding the Preliminary Objection or Request for Clarification. (1-1-93)

d. Failure of Payor to Object or Request. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill and/or a Request for Clarification within thirty (30) calendar days of receipt of the bill, it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (1-1-93)

07. Provider Reply to Preliminary Objection and/or Request for Clarification. (1-1-93)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection and/or Request for Clarification. (1-1-93)

b. Failure of Provider to Reply to Preliminary Objection. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (1-1-93)

c. Failure of Provider to Reply to Request for Clarification. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (1-1-93)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part and/or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (1-1-93)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (1-1-93)

10. Investigation of Claim Compensability. Where a Payor is investigating the compensability of a claim as to which a Provider has submitted a bill, the Payor must send a Notice of Investigation of Claim Compensability to the Provider and the Patient within fifteen (15) calendar days of receipt of the Provider's bill. The Payor shall complete its investigation of claim compensability and notify the Commission, the Provider and the Patient of its determination within thirty (30) calendar days of the date the Notice of Investigation of Claim Compensability is sent. Where a Payor does not timely notify the Commission, the Provider and the Patient of its determination, the Payor shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (1-1-93)

a. Single Objection Sufficient. A single objection stating that liability has been denied shall be sufficient for each Provider from whom a bill is received. (1-1-93)

b. Effect of Commission Determination of Claim Compensability. The thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall recommence running on the date of entry of a final Commission order determining that the claim is compensable. (1-1-93)

c. Effect of Determination of Compensability. If the Payor, absent a Commission determination of claim compensability, concludes that it is liable for a claim, the thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall begin running on the date the Payor notifies the Commission, Provider and Patient that it accepts liability for the claim. (1-1-93)

11. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors as Referenced in IDAPA 17.02.08.031 and 032 (formerly 17.01.03.803.a. and 803.b.). (1-1-93)

12. Requirements Regarding Disputes Arising Before the Effective Date of this Rule. (1-1-93)

a. Written Demand Required. If, prior to January 1, 1993, a Payor notifies or has notified a Provider that it does not intend to fully pay any charge for Medical Services incurred prior to January 1, 1993, the Provider seeking payment for such charge must send a written Demand for Payment to the Payor no later than January 31, 1993. (Note: Should the matter ultimately proceed to the dispute resolution phase set forth in the Judicial Rule, the Commission will resolve the dispute by applying the administrative rule which was in effect at the time the charge was incurred. Hence, if the charge in dispute was incurred prior to June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.01.03.803, then in effect. However, if the charge in dispute was incurred on or after June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.02.08.031, now in effect.) (1-1-93)

b. All Provisions of this Rule Will Apply. Such a Demand shall substitute for the bill and Report referenced in Subsection 032.03 above, and must contain all the information required by that section. Service of a timely Demand for Payment will bring the other provisions of this rule into operation. (1-1-93)

c. Failure of Provider to Make Written Demand. Providers failing to make a written Demand for Payment within thirty (30) calendar days of the effective date of this rule shall be forever barred from invoking the Dispute Resolution Process set forth in the applicable Judicial Rule. Demands and/or billings submitted previously either to the Payor or to the Commission will not suffice. (1-1-93)